DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/17/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRU A. BUILDING 01, 02			(X3) DATE COMP	SURVEY		
		155191	B. WING			R 09/14/2015			
NAME OF PROVIDER OR SUPPLIER				STR	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/	14/2010		
				221	0 GREENTREE N				
WESTMIN	STER HEALTH CARE CI	ENIER		CLARKSVILLE, IN 47129					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)		BE COMPLETION			
{K 000}	INITIAL COMMENTS		{K 0	000}					
	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 07/16/15 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 09/14/15 Facility Number: 000100 Provider Number: 155191 AIM Number: 100266130 At this PSR survey, Westminster Health Care Center was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The original building was surveyed with Chapter 19, Existing Health Care Occupancies. This one story facility with a basement was determined to be of Type V (111) construction and fully sprinkled. There is no fire separation between the original building and the new Rehabilitation Gym because the original building and Rehabilitation Gym are of the same construction type. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 94 and had a census of 52 in the healthcare portion of the facility at the time of this visit.								
	All areas where resid	ents have customary access							
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE	1		TITLE		(X6) DATE		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/17/2015 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 02			(X3) DATE SURVEY COMPLETED	
		155191	B. WING			R 09/14/2015	
NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER			l	2	STREET ADDRESS, CITY, STATE, ZIP CODE 2210 GREENTREE N CLARKSVILLE, IN 47129	03/	14/2013
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOUL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	BE COMPLETION	
{K 000}	services were sprinkle	I areas providing facility ed.	{K 0)00}			
{K 000}	Quality Review completed on 09/16/15 - DA INITIAL COMMENTS		{K 0	00)			
	Code Recertification a						
	Survey Date: 09/14/15						
	Facility Number: 000 Provider Number: 15 AIM Number: 100266	5191					
	Center was found in a Requirements for Par Medicare/Medicaid, 4 Life Safety from Fire a National Fire Protection Life Safety Code (LSG 2009 Rehabilitation G	· ·					
	determined to be of T fully sprinkled. The fa system with smoke do spaces open to the co capacity of 94 and ha healthcare portion of visit.	etection in the corridors and pridors. The facility has a d a census of 52 in the the facility at the time of this					
	All areas where reside	ents have customary access					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/17/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 02 B. WING			(X3) DATE SURVEY COMPLETED R 09/14/2015	
155191			B. WING _					
NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER				STREET ADDRESS, C 2210 GREENTREE N CLARKSVILLE, IN		1 03/	14/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU		BE COMPLETION		
{K 000}	were sprinkled and all services were sprinkle	I areas providing facility	{K 0	00}				